# Health report for adults being assessed to become adoptive parents or foster carers

This form is suitable to use for all fostering and adoption applications, including intercountry adoption/special guardianship/short break/respite care/kinship care, and can also be used when a full medical review is required for carers who are already approved.

***A commissioning letter from the fostering/adoption agency should accompany this form.***

Guidelines and process for completion

**Part A** *- to be completed by the agency*

It should clearly identify where the form should be returned when all sections are completed.

**Part B** *- to be completed by the applicant/carer*

**Confidentiality and storage** On completing part B/section 5, the applicant/carer confirms that they give consent for their health information to be shared with the agency. The health report will be stored confidentially on their social care record. After completion of AH, if additional information is required from health specialists further consent should be obtained from the applicant/carer.

**Part C** *- to be completed by a medical practitioner, usually the applicant’s/carer’s own GP*

The purpose of the completion of the medical report on the applicant is to obtain accurate and up-to-date information on the applicant’s individual and family health history and current physical and mental health. The medical practitioner completing Part C is not required to make a decision on suitability but to provide sufficient accurate and detailed information to enable the agency medical adviser to advise the agency. This information will assist the agency in deciding the applicant’s suitability to care for the child. It is important that the GP record is available to the assessing practitioner. Safeguarding concerns should be disclosed.

The agency medical adviser should be contacted if the doctor completing the form wishes to discuss any issues arising from the health assessment. **Part C is preferably completed in person but video consultation is an option.** For more information visit [corambaaf.org.uk/formah-gp](https://corambaaf.org.uk/formah-gp)

**Part D** *- to be completed by the agency medical adviser*

**Interpretation of Adult Health Report by agency medical adviser**

On receipt of the completed AH form, the medical adviser will provide a summary, and advice to the agency on the implications of an applicant’s current health and history. Further information for medical advisers is available at [corambaaf.org.uk/formah-ma](https://corambaaf.org.uk/formah-ma).

Why is this information needed?

The requirements to obtain information about prospective adoptive applicants and foster carers are laid down in the relevant adoption and fostering Regulations for England, Northern Ireland, Scotland and Wales, and this includes details about the health status of those applying to adopt or foster. Many children who are in the care system (looked after children) have a history of neglect and/or physical, sexual or emotional abuse and other adverse experiences. They are therefore likely to have a range of significant individual needs.

Prospective adopters and carers must have robust physical and mental health to be able to parent these vulnerable children. Health information about prospective adopters or foster carers and its interpretation form only one part of the application and supervision process and will be set alongside other information obtained by the agency in considering the suitability of applicants. The application process involves a panel making recommendations. It is unusual for health issues to prevent approval as carers/parents. The information provided is also used to assist appropriate matching of carers and children.

It is important that agencies satisfy themselves that applicants are able to meet the demands of parenting on a daily basis, and in the case of adoption and long-term placements, have a reasonable expectation of retaining good health to support children to adulthood.

PART A to be completed by the agency – in black ink or preferably electronically

**Health report for a** (tick as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
| **first application** |  | **review** |  |

Please indicate caring role below

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Fostering |  | tick if long term |  | Short break/respite care |  | |
| Adoption |  |  |  | Intercountry adoption |  | |
| Special guardianship |  |  |  | Kinship/connected person |  | |
| Other care |  |  | | | |
| Ages and number of children applied for (if specific child, provide details) | | | | | |
|  | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of agency | |  | | Social worker | |  |
| Address | | | | | | |
| **Telephone** | | | | Postcode |  | |
| Email | | |  | | | |
| Case reference number | | |  | | | |
| Name of medical adviser | | |  | | | |
| Employed by |  | | | | | |
| **Address** |  | | | | | |
| Telephone |  | | | | | |
| Email |  | | | | | |

**RETURN FORM when Parts B and C are complete TO**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Designation** |  |
| **Email** |  | | |
| **Post to** |  | | |

PART B to be completed by the applicant

1. Applicant details

Information about your health will be used to assist the application; matching and support processes. Please try to give as much accurate information as possible.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Family name of applicant | | |  | | | | |
| First name |  | | | Gender |  | | |
| Address |  | | | | | | |
| **Tel** |  | | | Email |  | | |
| Date of birth |  | | | Occupation |  | | |
| Ethnicity |  | | | | | | |
| GP details  Name and address |  | | | | | | |
| Name of partner if applying jointly |  | | | | | | |
| 2. Current health | | | | | | |  |
| **Do you consider yourself to be in good health currently?** | | | | | | **Yes/No** | |
| Please give details | |  | | | | | |
| Are you seeing any specialists or hospital consultants? | | | | | | Yes/No | |
| If yes, give details of who you see and where | | | | | | | |
|  | | | | | | | |
| **What do you see him/her for?** | | | | | | | |
|  | | | | | | | |
| **Do you attend the GP for regular appointments?** | | | | | | | **Yes/No** |
| **If yes, what are these appointments for?** | | | | | | | |
|  | | | | | | | |
| Do you take any medication regularly? | | | | | | | Yes/No |
| If yes, please list below and clarify what each is for | | | | | | | |
|  | | | | | | | |
| Have you had any health issues in the past? | | | | | | | Yes/No |
| If yes, please give details | | | | | | | |
|  | | | | | | | |
| Have you had any emotional or mental health problems such as anxiety, depression or stress? | | | | | | | Yes/No |
| If yes, please give details. Include any life events that may have been triggers | | | | | | | |
|  | | | | | | | |
| **Do you have any significant sleep difficulties?** | | | | | | | **Yes/No** |
| Have you ever seen a psychiatrist/psychologist/psychotherapist/ counsellor/psychiatric nurse/other health or social work professional or complementary therapist for issues related to mental health? | | | | | | | Yes/No |
| If yes, please give details and dates | | | | | | | |
|  | | | | | | | |
| **Are you awaiting an appointment regarding your mental health and emotional well-being?** | | | | | | | **Yes/No** |
| **If yes, please provide details and dates** | | | | | | | |
|  | | | | | | | |
| Have you ever attended a private health clinic or hospital? | | | | | | | Yes/No |
| If yes, provide details and dates | | | | | | | |
|  | | | | | | | |
| Are you on any benefits related to sickness, incapacity or disability? | | | | | | | Yes/No |
| If yes, please give details | | | | | | | |
|  | | | | | | | |
| **Do you have any dental problems?**  **How often do you attend the dentist?** | | | |  | | | |
| **Do you have any significant problems with your vision or hearing?** | | | |  | | | |

# 3. Family history

Provide details about the health of your family. Does anyone have any serious health problems? Does anyone have any genetic conditions that may run in the family?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Age | State of health if living  (if known) | Age at death and cause  (if known) |
| Father |  |  |  |
| Mother |  |  |  |
| Brothers and sisters |  |  |  |
| Children |  |  |  |
| Other (please specify) |  |  |  |
|  |  |  |  |

# 4. Lifestyle

|  |  |
| --- | --- |
| What exercise or activity do you do? | How long for and how often? |
|  |  |
| Describe your diet and any dietary restrictions | |
|  | |
| **What do you feel keeps you healthy?** | |
|  | |

|  |  |
| --- | --- |
| Do you smoke tobacco? (cigarettes, pipe, roll-ups) | Yes/No |
| If yes, how long have you smoked? |  |
| How many do you smoke per day? | * **Less than 1** * **1-5** * **6-10** * **10 +** |
| If NO, have you ever smoked tobacco? | Yes/No |
| How many years did you smoke for? |  |
| When did you stop smoking? |  |
| Do you currently use an electronic cigarette (vaping device)? | Yes/No |
| Do any other household members smoke? |  |
| Where are visitors/household members allowed to smoke in your home? |  |
| Do you drink alcohol? | Yes/No |
| What type of alcohol do you drink? | * Beers/cider * Spirits * Wines |
| How much do you drink on average a week? Describe in glasses/bottles or units |  |
| Have you ever used recreational/street/illegal drugs? | Yes/No |
| If yes, please describe use, including when and type of substance |  |
|  | |
| What is your current weight? |  |
| What is your current height? |  |
| Please describe whether you have had any fertility treatment? |  |
| What were the dates of this treatment? |  |
| Have you accessed any counselling in relation to the treatment? If so, please give details, and say whether this continues | |
|  | |
| Please describe your pregnancy history, including any pregnancy losses | |
|  | |

# 5. Consent

I certify that to the best of my knowledge the above information is complete and accurate.

I understand that the information about my medical history and present medical condition recorded on this form is required by the named agency.

I consent to a medical examination, and for the examining medical/health practitioner to access my medical records.

I consent to the provision of this report to the agency, understanding that it will be viewed by relevant staff and the agency medical adviser and will be stored confidentially by the agency.

I consent to the agency medical adviser viewing my electronic health record and requesting further information from my GP if required.

I understand that I am responsible for informing the agency if there are any significant changes to my health.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of applicant |  | Date |  |

PART C to be completed by an appropriate health professional, usually the applicant’s GP

In adoption, the report must be completed by a medical practitioner. This form will be viewed by the commissioning agency including the applicants’ social worker and the medical adviser for the agency. For more information visit [corambaaf.org.uk/formah-gp](https://corambaaf.org.uk/formah-gp)

Please review the information provided by the applicant in Part B and complete the following sections 1 to 6.

|  |  |
| --- | --- |
| **The applicant has completed Part B, a questionnaire about their own health, and I have had the opportunity to review this information as part of this assessment** | **Y/N** |
| **Please comment on accuracy of self-reported information** | |
|  | |

1. General

|  |
| --- |
| Are you the applicant’s usual GP? If not, explain current role |
|  |
| How long have you known the applicant? How long have you treated the applicant? |
|  |
| At what date do their records (please consider written and computerised records) begin? Do the records appear to be continuous? If not, please provide details of any breaks. |
|  |
| Safeguarding  Do you know anything about the applicant’s lifestyle/health/history that might impact their capacity to care for a child or put a child’s welfare at risk? (Please review all records available)  Yes/No  Please give details. |
|  |
| **Has a GP previously completed a medical report for adoption and fostering purposes for this applicant/carer, according to records?** |
|  |
| When and for what purpose did they last consult your practice? |
|  |
| **Are they currently receiving any treatment/care for current health issues?** |
|  |
| Are they currently receiving/being prescribed any medication or other treatment?  If yes, please specify |
|  |

# 2. Medical history

Please give details of any conditions (including treatment and investigations, dates and duration) or write NONE

|  |
| --- |
| Medical conditions |
|  |
| Previous surgery/planned surgery |
|  |
| Trauma/accidents |
|  |
| Pregnancy history/history of infertility treatment. *(Applicants are encouraged to discuss these experiences with their social worker, particularly when considering adoption). Include detail, giving consideration to type of application.* |
|  |
| Infectious diseases (current or previous and significant) e.g. Hepatitis C, Hepatitis B, HIV, TB (include test results and treatment details) |
|  |
| Immunisations (Hepatitis B immunisation is recommended for foster carers and intercountry adopters) |
| **Has been vaccinated as per recommended schedules (including flu/Covid) Y/N**  **Comments:**  **Hepatitis B vaccination previously Y/N**  **BCG vaccination previously Y/N** |

# 3. Mental health

|  |
| --- |
| Any history of mental illness/mental health problems (includes anxiety, stress, personality disorders, self-harm and psychoses). Please include details of identified triggers |
|  |
| Have they ever received medication for a mental health issue? Please give details, including duration of treatment |
|  |
| Any psychiatric or psychological treatment or counselling/psychotherapy? (Specify and give dates and duration) |
|  |
| Any emotional/relationship problems? |
|  |
| Have there been any periods of not being able to work due to mental health issues? If yes, please give details |
|  |
| If there have been mental health difficulties/emotional problems, how would you assess the applicant’s present condition? |
|  |

# 4. Consultations

Provide details of past and present consultations with specialists.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Specialist’s name | Hospital and patient reference number | Reason/details/dates |
| Past |  |  |  |
| (if relevant) |  |  |  |
|  |  |  |  |
| Present |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please send copies of hospital and consultant reports with the completed form

# 5. Examination

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Measurements (in light clothes) | Height | |  | | cm |
|  | Weight | |  | | kg |
| Body Mass Index (BMI) |  | | | | |
| If BMI > 30, take waist measurement | Waist circumference | |  | | cm |
| **If BMI is over 30 what is the plan to follow this up?**  **Is there a weight reduction plan?** |  | | | | |
| Blood pressure: | | | | | |
| Please take urine sample (essential) | | result | |  | |
| **Please complete cardiovascular risk score (if indicated)** | |  | | | |
| Is further physical examination indicated giving consideration to history, baseline measurements, presentation or patient concerns? If so, please record | |  | | | |
| Any further clinical findings or recommendations?  Have you arranged for further investigations/treatment resulting from this appointment? | |  | | | |

# 6. Impact of physical and mental health

Please comment on how the applicant/carer copes physically and mentally with any chronic condition, e.g. management of condition, ability to work, limitation in daily activities, and how this may affect parenting capacity.

|  |
| --- |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | | | | | | | |
| GMC Registration number | | Qualifications | | | | | | |
| Address | | | | | | | | |
|  | | | Postcode | | |  | | |
| Telephone |  | | | | | | | |
| Email |  | | | | | | | |
| How was Part C completed? (tick as appropriate) | | | | **in person** |  | | **via video consultation** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date |  |

**Form should be returned as per the instructions on the bottom of page 1 Part A.**

**Please do not return this form under any circumstances to CoramBAAF**

**PART D** Summary report from agency medical adviser

(this may be completed on a separate document depending on local arrangements)

This will be entered into Form F/the Prospective Adopter’s Report and read by the panel and applicant.

Further information for medical advisers is available at [corambaaf.org.uk/formah-ma](https://corambaaf.org.uk/formah-ma)

Summary of health and lifestyle issues with comments on the significance for adoption/fostering.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| Name |  | | Designation | |  |
| Qualifications | | | | | |
|  | | | | | |
| Address | | | | | |
|  | | | | | |
|  | | Postcode | |  | |
| Email |  | Telephone | |  | |
| Signature |  | | Date | |  |